EBS Benefit Solutions
An Excellus Company

[redacted]

Flexible Spending Account
Health Care/Dependent Care
Reimbursement Form

www.myebsaccount.com to submit claims on-line

Employer Name

Employee First Name | M.I. | Last Name

Address ☐ Check here if new address

City | State | Zip Code

Email Address

Social Security Number

Name	Relationship To Employee SELF, SPOUSE, CHILD OTHER (SPECIFY)	Amount	Date(s) Of Service	Description Of Service	CLAIM REF #	OFFICE USE ONLY
					01	
					02	
					03	
					04	
					05	
					06	
					07	
					08	
					09	
					10	

Instructions on reverse side

IMPORTANT: SIGNATURE REQUIRED BELOW

I certify the information here is true and correct, that the expenses incurred were for myself, spouse, or qualified dependents, and that these expenses are not reimbursable under any other health plan coverage.

DATE: EMPLOYEE SIGNATURE:

INSTRUCTIONS

1. If you are submitting expenses eligible under another insurance plan, you **must** submit an Explanation of Benefits (EOB) statement.

2. Copies of all bills (and EOB if required) for reimbursement must be enclosed with this completed reimbursement form.

   Bills must include:

   - Name of person providing the service
   - Dates of service
   - Description of the service(s) rendered
   - The amount charged
   - The name of person receiving services
   - For over-the-counter drugs, circle or highlight eligible item(s) on your receipt, and list each item separately on your reimbursement form.

   Balance bills, canceled checks, etc. are **not** acceptable.

3. Dependent care expenses must include:

   - Name and address of person providing care
   - Date(s) of service
   - Name of dependent receiving care
   - Amount charged
   - Tax identification or Social Security number (if required by employer)
   - Receipt must be on provider letterhead or include provider signature

4. All claims must be received at least 5 business days prior to your scheduled reimbursement date.

If you have any questions, please call our Customer Service Department at: 1-800-327-7130. Visit us on the web at **www.myebsaccount.com**

SEND COMPLETED CLAIM FORM TO:

Mail: EBS Benefit Solutions, Inc.
PO Box 22999
Rochester, NY 14692

Fax: 1-877-256-7228

Please note: Faxing or mailing your claim may increase processing time. For faster processing time, submit your claim on our website at www.myebsaccount.com.